Appendix 22 ▪ Care Plan

Client Name:		**MSSP #:**		**Care Plan Conference Date:**		**Duration of Care Plan**	

Date	**Problem #**	**Problem Statement**	**Client Goal/ Outcome**	**Service Provider & Type (I, R, P, C)**	**Plan/Intervention**	**Date Resolved/ Comments**

MSSP Staff Signatures:			
PCM:	**Date:**	**SCM:**	**Date:**
I acknowledge receipt and acceptance of this Care Plan, and receipt of the notice regarding my rights to a fair hearing if I am dissatisfied with the action(s) affecting MSSP-funded services.		***X*** **Date:**	
		Client's Signature	